

# Lexall Limited - Lexall Care

---

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Lexall Limited
<b>Premises audited:</b>	Lexall Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 20 April 2021    End date: 21 April 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	48

# Executive summary of the audit

---

## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Lexall Care is privately owned. The service is certified to provide rest home and hospital (medical and geriatric) level care for up to 58 residents. On the day of the audit, there were 48 residents. The residents, relatives and general practitioner commented positively on the care and services provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff, and the general practitioner.

The service is managed by a full time experienced clinical manager who has been in the role for over 19 years. The clinical manager is supported by an experienced charge nurse and the general manager (owner), who purchased the facility in 2000.

There are no shortfalls identified during this audit.

The service is commended for achieving continuous improvement ratings around the following two areas: good practice with the further development and implementation of an agile and the quality improvement system.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

All standards applicable to this service fully attained with some standards exceeded.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Services are planned, coordinated and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. An electronically documented quality and risk management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, seven days a week. The integrated electronic resident files are appropriate to the service type.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent caregivers responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
--	--	--

The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

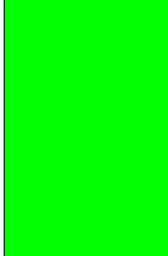
## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint

minimisation. There were seven restraints used during the audit (lap belts and bedrails) and nine enablers (one lap belt and eight bedrails).

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
--	---	---

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (RN) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training through an online provider in addition to Covid education provided by the local DHB. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	2	99	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff (three caregivers, two registered nurses (RN), the clinical manager, cook, activities coordinator, charge nurse), along with the general manager (director), and assistant general manager confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Six residents (three rest home and three hospital level) and five relatives (hospital level of care including one under an ACC contact and one under an interim care contract) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents were included in the admission process as sighted in seven resident's files reviewed (five hospital and two rest home). Consent forms are signed for any specific procedures.</p> <p>Caregivers interviewed confirmed consent is obtained when assisting with care. Advance directives sampled identified the resident resuscitation status and/or signed by the resident (if appropriate) and the general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of enduring power of attorney (EPOA) were seen in the</p>

		<p>resident files as appropriate.</p> <p>Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Admission agreements were sighted for the long-term residents.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility, including activities of daily living, for example, shopping and attending cafes and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff interviewed were aware of the complaints process and to whom they should direct complaints. A complaints register has been maintained.</p> <p>There have been four complaints made in 2020 and one complaint received in 2021 year-to-date. There was documented evidence of response, follow-up, and resolution to the complaints reviewed. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p> <p>There has been one serious complaint made in 2020 which was reported to the district health board (DHB) by the service. The complaint was withdrawn by the complainant soon after the complaint was lodged.</p>
<p>Standard 1.1.2: Consumer Rights</p>	FA	<p>The service provides information to residents that include the Code, complaints, and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss</p>

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>with the resident. Residents and relatives interviewed identified they are well informed about the Code. Quarterly resident meetings provide the opportunity to raise concerns. An annual residents/relatives' satisfaction survey is completed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, residents' privacy, and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Lexall Care has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there was one resident who identified as Māori. A review of one of the resident's files identified involvements in specific Māori community events as requested by the resident. Māori consultation is available through a local Māori kaumātua as required. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori.</p> <p>The general manager (director) also owns a sister service in Kaikohe and as a result has links to Māori for advice and support if required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family is invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.</p> <p>The service has a group of eight Asian residents. The service has put in place activities that cater for their needs including specific spiritual events, food options and interpreting service that support each resident. The non-Asian residents interviewed stated that they enjoyed the cultural diversity the service offered, and all had friends in the service of different ethnicities.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There is a comprehensive and implemented discrimination and harassment policy in place. Job descriptions include responsibilities of the position and ethics, advocacy, and legal issues. The comprehensive orientation programme provided to staff on induction includes dignity and privacy. Interviews with staff confirmed an understanding of professional boundaries. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.</p> <p>Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there were to be an infringement with the person concerned.</p> <p>Residents interviewed felt that they were not exposed to exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>There is an electronic master copy of policies, which has been developed in line with current accepted best practice and these are reviewed regularly or at least two-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data is collected against each service level. The clinical manager and charge nurse collate and monitor data with all discussed at the relevant meetings. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff. Quality improvement plans (QIPs) are developed where results do not meet targets.</p> <p>Health professionals are engaged to support a resident when required. A general practitioner visits residents twice per week with on-call medical services available 24/7. In the selection of resident files reviewed, care plans reflected input from physiotherapists, dietitians, and podiatrists. Residents and family interviewed confirmed that they were very satisfied with care provided.</p> <p>A rating of continuous improvement has been given to the implementation of an electronic resident information system (Lexall Care) that has resulted in improvements in the care provided to residents. Staff are specifically employed and are on site to further develop the system and to respond to any queries. The IT system is responsive, agile and a collaborative tool for documentation.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive</p>	<p>FA</p>	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents and fifteen incident forms reviewed confirmed this. Resident/relative meetings are held quarterly. The clinical manager and the</p>

<p>to effective communication.</p>		<p>charge nurse have an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p> <p>Residents and family interviewed stated that the service kept them well informed at every step of the pandemic including updating them around residents' wellbeing and activities during periods of lockdown.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Lexall Care is privately owned. The service is certified to provide rest home and hospital (medical and geriatric) level care for up to 58 residents. On the day of the audit, there were 48 residents. There are five designated rest home beds with all others identified as dual purpose. There are 10 residents at rest home level of care including one long-term support chronic health conditions (LTS-CHC), and 38 at hospital level including one LTS-CHC, one funded by ACC and one on an interim care contract.</p> <p>The general manager (director) has 21 years' experience as owner/manager of Lexall Care and 5 years' experience as owner of a sister service in Northland. An assistant general manager has been in the role for four months and has a Bachelor of Commerce majoring in finance and economics. The service is managed by a full-time experienced clinical manager/RN who has been in the role for over 19 years. They have a postgraduate certificate in health and over 37 years' experience in aged care. A charge nurse with over seven years' experience in aged care also supports the clinical manager. All of the management team have maintained a minimum of eight hours relating to managing an aged care service, management, and leadership.</p> <p>A 2021 business/strategic and management plan is being implemented. The clinical manager reported that the management team meets regularly, and meetings include reviewing the strategic goals. Quality goals are also documented for the service. These goals link to the business/strategic and management plan and are regularly reviewed in staff meetings. A quality assurance annual report was completed for 2020 to review the actions in place to achieve the quality goals.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate,</p>	<p>FA</p>	<p>During a temporary absence, the administration/finance manager and charge nurse cover the clinical manager's role. The general manager provides oversight and support.</p>

and safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management programme is documented electronically.</p> <p>Policies and procedures are managed on the Lexall Care server in the first file under the Lexall File QA (Quality Assurance) section. Once an update is completed the policy is then uploaded into its appropriate section under QA on the 'Intranet'. Staff were seen using the electronic system easily, and they stated that this was available internally and externally. There is a spread sheet with all the documents listed and the month they are next due to be reviewed. Policies are also updated by an external consultant and as these are received, they are personalised to meet the facilities needs and the spread sheet is adjusted accordingly. Policies and procedures are also adjusted as the need arises to improve the quality of service, usually as a result of issues raised from the QA monthly meeting or the QA Improvement meetings. Again, the spread sheet is adjusted as needed.</p> <p>Quality data is collected for adverse events including falls and skin tears, restraint, pressure injuries (if any), and infections. This data is collated, trended, and analysed and is regularly communicated to staff at the quality assurance and staff meetings. Required actions and resolutions from facility meetings are documented. Minutes of these meetings are made available to all staff. A resident/family satisfaction survey was last completed in July 2019. Overall nursing care was rated by respondents as being 98% satisfied or very satisfied at the last 2019 survey. A survey was not completed in 2020 because of the pandemic but one has been completed in 2021. The returns show a very high level of satisfaction with the service. Collation of data is in progress and a documented corrective action plan will be put in place to follow up on identified areas of improvement if any are identified. There are quarterly residents' meetings conducted and families are invited to attend.</p> <p>The service has identified quality goals for 2020 and 2021 with a focus this year on restraint minimisation, refurbishment, reduction of challenging behaviour and reduction of skin infections. The service has successfully reduced repetitive falls by 16% across the service by end of 2020. In 2021, the data shows that there has continued to be a significant reduction in falls in general with only seven recorded in March 2021 (in 2020, prior to the project being started there was an average of 18 falls per month).</p> <p>The service has already started a project that is focusing on a reduction of skin infections. Baseline data has been recorded, the project group has been identified, meetings have been held with product suppliers with trials of continence products and barrier creams starting. A quality service agreement has been made with care staff to get their buy-in and commitment to the project that includes attendance at education, use of strategies and interventions identified and in the project. Additional training has been arranged with a continence worksheet completed with arrangements for the DHB nurse and product specialists to provide additional education and training.</p> <p>Internal audits are completed as documented in the audit schedule. Corrective actions are</p>

		<p>consistently followed up and completed when internal audit findings are identified.</p> <p>A health and safety programme is in place that meets legislative requirements. The health and safety programme is managed as per the Health and Safety policy. All incidents, risks, hazards, and audit outcomes are logged on the online system and reviewed by either the clinical manager (CM) or charge nurse (RNC). An action plan is set and then signed off once completed. QA monthly meetings are held to monitor all health and safety issues and the QA meeting minutes are posted on the 'Intranet' noticeboard for all staff to read. Important issues are fed back to the QA staff meetings and the system is overseen by the assistant manager. The clinical manager is the health and safety representative (interviewed). Staff education, which begins during their induction to the service, includes the topic of health and safety. Falls prevention strategies include the use of sensor mats and implementing strategies for frequent fallers.</p> <p>The service has been awarded two ratings of continuous improvement; i) for the work completed to reduce falls and ii) for the way the electronic system has been developed and implemented to form a cohesive quality improvement platform that informs clinical care as well as providing a 'one stop shop' for analysis and reporting.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Individual reports are completed for each incident/accident with immediate action noted including any follow-up action(s) required. Incident/accident data is linked to the facilities quality and risk management programme. There were 23 accident/incident forms reviewed during the audit. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observations have been undertaken if there is a suspected head injury as per policy. The clinical manager is aware of the responsibility to notify relevant authorities in relation to essential notifications. One unofficial complaint that was later withdrawn was forwarded to the DHB. There have been no other requirements to complete a section 31 notification since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies address recruitment, orientation and staff training and development. Eight staff files selected for review (one clinical manager, one charge nurse, two RNs, two caregivers, one assistant general manager, and one activities coordinator) included evidence of the recruitment process including police vetting, signed employment contracts, reference checks and annual performance appraisals. Sign off of completed orientation programmes and checklists confirmed the orientation process. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service.</p> <p>There is an annual education and training schedule for 2021 that is being implemented. Education</p>

		<p>and training for the RNs are supported by the DHB. There are nine RNs (including the clinical manager and charge nurse) and two have completed interRAI training with one in training. Medication competencies are up to date. Current annual practising certificates were sighted for the registered health professionals. There is a minimum of one staff member available 24/7 with a current first aid/CPR certificate.</p> <p>The service has 27 caregivers and seven caregivers have completed level 7 NZQA qualification; nine at level 4; four at level 3, six at level 2. The activities coordinator has been in the role for three years' and is currently completing the Certificate in Diversional Therapy.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A staffing plan is documented for the service. The clinical manager and charge nurse are available five days a week (Monday to Friday) and are on call 24/7. The facility is split in to five wings. With wings 1, 2, 3 upstairs and 4 and 5 downstairs on the ground floor.</p> <p>In wing one, two and three there are 35 beds with 29 residents in total (seven rest home and 22 hospital level). There is one RN on duty on the morning and afternoon shifts. They are supported by three caregivers on the morning and afternoon shifts (two long and one short shift).</p> <p>In wings four and five there are 23 beds with 19 residents (five rest home and 14 hospital level). There is one RN on duty on the morning and afternoon shifts. They are supported by three caregivers on the morning and afternoon shifts (two long and one short shift).</p> <p>There is one RN overnight, and they are supported by three caregivers on the night shift across both floors.</p> <p>Staff working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Rosters reviewed for the past three months confirmed that staff were replaced when on leave. Residents and family members interviewed reported there are sufficient staff numbers. Residents also stated that staff provide intentional rounding at least two hourly but more often if the resident is identified as a high falls risk.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	FA	<p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office with password protection on electronic files.</p> <p>Care plans and notes were legible and where necessary signed (and dated) by a registered nurse</p>

accessible when required.		noting that most documentation is electronically recorded. Entries are legible, dated and signed by the relevant caregiver or RN including designation. Individual resident files demonstrate service integration. There is an allied health section on the electronic system that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. These notes are integrated into the resident notes.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The clinical manager and charge nurse screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment, and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The seven admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the clinical manager or charge nurse are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission in to the facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-medicating on the day of audit, who had been assessed as competent to self-administer by the RN and GP. The resident's room was visited</p>

<p>safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>and confirmation that the medications were stored securely obtained. All legal requirements had been met. There are standing orders in use which are comprehensively documented, including indications for use, frequency, and maximum doses. These are reviewed three-monthly by the GP. There are no vaccines stored on site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications, have up-to-date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridges and room temperatures are checked daily. Eye drops viewed in both medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The lead cook oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring November 2021. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu is approved by an external dietitian. The service offers a Korean menu once per week which is available to all residents should they prefer it to the main offering.</p> <p>All resident/families interviewed are happy with the meals. Additional snacks are available at all times.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>

the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed excluding one funded by ACC and one interim care. Initial interRAI assessments and reviews are evident for five of seven resident files sampled.</p> <p>Resident files reviewed identify that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietitian, wound care specialist and PEG nurse specialist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence</p>

		<p>and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included six chronic wounds, eight skin tears, two grade 2 pressure injuries (facility acquired) and one resident with three grade 2 and one grade 1 community acquired pressure injuries. There was evidence of wound nurse specialist involvement in chronic wounds/pressure injuries.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, and wounds. All monitoring requirements including neurological observations had been documented as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is one activity coordinator covering Monday to Friday who plans and leads all activities. The service designates weekends as 'family time' and also arranges visiting entertainers to attend on some weekends. Residents were observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, pet therapy, floor games and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered.</p> <p>There are weekly outings, and the service utilises a community wheelchair accessible minibus and volunteer transport as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. There are visiting community groups such as cultural dance groups, churches, and children's groups. Korean specific entertainment including music, entertainers and Korean thanksgiving also occurs and is open to all residents.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive</p>	FA	<p>Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six monthly multi-disciplinary review (MDR) is also completed by the registered nurse with input from caregivers, the GP, the activities coordinator, resident and family/whānau members and any other relevant person</p>

<p>and timely manner.</p>		<p>involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The charge nurse interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the charge nurse and registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a building warrant of fitness which expires December 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, expiring February 2022. The hoist and scales are checked annually and are next due to be checked March 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and decked areas are well maintained. All external areas have attractive features, including views of the surrounding hill country and are easily accessible to residents. All outdoor</p>

		areas have some seating and shade. There is safe access to all communal areas.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	All resident rooms have either an ensuite toilet or a full ensuite. There are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	There is one double room, and all other resident's rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large and small communal areas. There is a large, dedicated activities room, however activities occur in all areas of the facility, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are spacious, inviting, and appropriate for the needs of the residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being</p>	FA	All laundry is outsourced. There is a separate 'dirty' area for linen/clothing awaiting collection and a 'clean' area for deliveries. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use.

provided.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for three litres per person, per day for three plus days for resident use on site. A generator is readily available on rental through a local company.</p> <p>There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. There is security lighting externally and CCTV covering entrances, exits and corridors.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled, with newly refurbished rooms also having individual heat pumps. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (charge nurse) is an RN who is responsible for infection control across the facility as detailed in the infection control coordinator job description (signed copy sighted on day of audit). The coordinator oversees infection control for the facility, reviews incidents on the electronic resident management system and is responsible for the collation of monthly infection events and reports. The facility management team are responsible for the development of, and annual review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There have been no outbreaks since the last</p>

		<p>audit.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE.</p> <p>An organisational COVID strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, PPE and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE, these details being passed on to families via email and in writing. During Covid lockdown the service implemented weekly staff briefings which allowed for updates, education and discussion. All visitors are required to provide contact tracing information.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Lexall Care. The infection control coordinator liaises with the infection control committee who meet regularly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The infection control coordinator has completed annual training in infection control through the local DHB.</p> <p>External resources and support are available through an online learning portal, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the clinical manager with input from the DHB infection control specialist.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating education and ensuring staff complete the online training available on the 'care online' internet-based education system. Training on infection control is included in the orientation programme. Staff have completed online infection control study in the last 12 months. The infection control coordinator has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Lexall Care surveillance policy. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the registered nurse, staff, and infection control meetings. Meeting minutes are available to staff.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. There were seven restraints used in the service (two lap belts and five with bed rails) and nine enablers (one lap belt and eight bed rails). There is a current quality improvement project started to work on reducing the use of bed rails in the facility. Any use of enablers is voluntary as per policy. Staff receive training around restraint minimisation that includes annual competency assessments. One resident file was reviewed for a resident using an enabler. This confirmed that the resident had given their consent. The need for the enablers was reviewed three-monthly.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (charge nurse) and for staff are documented and understood. The charge nurse interviewed was able to describe their role in the use of restraint and in overseeing implementation of the care plan. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

education on restraint use and this process is made known to service providers and others.		
<p><b>Standard 2.2.2: Assessment</b></p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Two hospital level residents where restraint was in use (two bed rails) and one rest home resident using enabler (bedrails), were selected for review and all files contained completed assessments. The completed assessments considered those listed in 2.2.2.1 (a) - (h). The restraint coordinator in partnership with the RNs, GP, resident, and their family/whānau, complete the assessment process. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident.
<p><b>Standard 2.2.3: Safe Restraint Use</b></p> <p>Services use restraint safely</p>	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident and usually two-hourly.
<p><b>Standard 2.2.4: Evaluation</b></p> <p>Services evaluate all episodes of restraint.</p>	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality and staff meetings. Evaluation timeframes are determined by risk levels. The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k).
<p><b>Standard 2.2.5: Restraint Monitoring and Quality Review</b></p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	Internal restraint audits measure staff compliance in following restraint procedures. Reviews are completed three monthly or sooner if a need is identified by the restraint coordinator. Any adverse outcomes are reported at the monthly quality assurance meetings.

## Specific results for criterion where corrective actions are required

---

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display
--------------------

## Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The implementation of an electronic resident information system (Lexall Care) has resulted in improvements in the care provided to residents.</p>	<p>The Lexall Care electronic resident information tool has been implemented that allows for more one-on-one time with residents and less paper-based documentation (e.g., care plans, monitoring charts). Interventions (e.g., weight management, falls management strategies, pain management, behaviour management) documented on Lexall Care are implemented and are reviewed daily by the clinical manager, charge nurse and registered nurse. Lexall Care’s care plans provide evidence to indicate when cares are being delivered.</p> <p>Interviews with care staff confirmed that there initially was a settling in time for the implementation of the electronic tool, however the system now allows for a greater amount of time to be spent reviewing the care plan with the resident in the resident’s room and assists caregivers in remembering to record when specific cares are being delivered (e.g., turning charts, food and fluid intake and output). Another positive aspect of the Lexall Care system is real-time notification to the care staff when there is a change to the resident’s care plan. Care staff interviewed stated that they get to know the residents better on Lexall Care. In the past they did not have enough time to read the paper-based clinical records and the system allows easy access to relevant and important resident information. This was also confirmed during resident interviews.</p> <p>The IT staff along with input from staff in the care centre have continued to update the system. The</p>

			<p>'Intranet' programme developed in and for the facility continues to be updated and tweaked to fit the facilities needs and changes to policy (i.e., changes to privacy legislation). Staff stated that they find it easy to use as it streamlines documentation and communication. Changes made to the 'Intranet' programme since the last audit have included a 'Master Section' created for doctors' rounds where nursing staff enter a request or reason to be seen, and the doctor follows with documentation of their notes after visiting the resident. These automatically go to each resident's notes. The link in this section gives the doctor immediate access to laboratory tests and latest observations. The 'Kitchen Board' created under communication allows for messages and requests to be left. The messages from care staff go directly to cooks and they do not have to troll through more general information to find kitchen specific notes. A computer station was set up in the kitchen for cooks to access the system quickly and easily.</p> <p>Residents stated that the care staff spend more time with them and understand them to a greater degree. This has resulted in more effective communication and happier residents.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Falls have reduced and have remained low.</p>	<p>Data collected and collated is used to identify areas that require improvement. Clinical indicator data and data related to service delivery has individual reference ranges for acceptable limits. A continuous improvement project has been completed that focused on reducing the number of repetitive falls in residents with cognitive loss and/or sudden or increasing frailty over a defined period. All data is recorded on the Lexall Care electronic quality and care system that provides a one stop programme for accessing resident information; incident, accident, and complaints data; reports from audits etc. Residents falls are monitored monthly with strategies implemented to reduce the number of falls including: medication reviews by the district health board pharmacist for identified at risk residents; the use of 'as required' medication for residents with agitation alongside increased monitoring of risk; updating of the behavioural management policy that included wandering, forgetting to use mobility aids and those who continuously tried to get up; a review of an increase in equipment to monitor and support residents (e.g., sensor mats and beams); development of behavioural management checklists to reduce anxiety and behaviours; education for all staff at the monthly quality assurance meetings, staff meetings and through the electronic noticeboards; support from the DHB nurse specialist; physiotherapy assessments for all residents during their entry to the service and for all residents who have had a fall; routine checks of all residents specific to each resident's needs (intentional rounding).</p> <p>Caregivers and RNs interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The falls prevention programme is reviewed monthly and is regularly discussed at staff and quality assurance meetings. The outcome for the nine residents enrolled onto the project showed that 44% of these residents had a significant decrease in the number of falls over the six-month period, 22% had a slight reduction in falls and 11% (one resident) had an increase in the number of falls despite multiple and numerous approaches being used consistently. Overall, strategies</p>

			also extended to other residents who had falls as staff became better informed and started as a collective group to introduce strategies. Overall, at the end of the project, there has been a 16% reduction in falls in the second half of 2020. Strategies, training, and policies/procedures used in the project are now included in the quality assurance policy, education plan and in monitoring of falls monthly.
--	--	--	--

End of the report.